**From:** Kim Aguilera [mailto:kaguilera@babbitt-johnson.com]
**Sent:** Monday, July 16, 2012 4:31 PM
**To:** Brett, Nicole E.
**Cc:** Joseph Osborne
**Subject:** NexGen - Norma Blake - PFS
**Importance:** High

Attached hereto is the Plaintiff Fact Sheet for Norma Blake and all records in our possession. Please let me know if you should need anything further.

Kimberley Aguilera, legal assistant to
Joseph A. Osborne, Esquire
Stephan Le Clainche, Esquire
Babbitt, Johnson, Osborne & Le Clainche, P.A.
1641 Worthington Road, Suite 100
West Palm Beach, FL 33409
(561) 684-2500
(561) 684-6308 - Facsimile

PLAINTIFF FACT SHEET OMITTED
TO PROTECT CONFIDENTIALITY

938753
5/26/08 IN

LAW OFFICES
BABBITT
JOHNSON
OSBORNE &
LeCLAINCHE
PROFESSIONAL ASSOCIATION
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WEST PALM BEACH, FLORIDA 33409
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THEODORE BABBITT*
JOSEPH R. JOHNSON*
JOSEPH A. OSBORNE
STEPHAN LE CLAINCHE*

PLEASE REPLY TO
POST OFFICE BOX 4426
WEST PALM BEACH, FLORIDA 33402-4426

*BOARD CERTIFIED CIVIL TRIAL LAWYER

AUG 30 2011

Thursday, August 25, 2011

9-11
1 Pg

SCANNED

JFK Medical Center
Attention: Medical Records
5301 S. Congress Avenue
Atlantis, FL 33462

Re: Norma Blake
Social Security No.: [redacted]
Date of Birth: [redacted]
Dates of Service: 2008

Dear Sir or Madam:

Please be advised that this firm is privileged to represent Norma Blake. Enclosed is a properly executed medical authorization signed by Norma Blake.

I would appreciate receiving a copy of your **IMPLANT SHEET** relative to care and treatment rendered to Norma Blake as well as a copy of your statement of charges for her 2008 surgery.

Please be advised that this request is made pursuant to the Federal Health Privacy Law and Health Insurance Portability and Accountability Act (HIPAA) as detailed in the signed authorization.

Thank you for your cooperation and prompt attention to these requests.

Very truly yours,

Christine L. Whitehead

cc: Client

54577771

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: NORMA BLAKE Social Security No.: [redacted]
Date of Birth: [redacted]

Authorized Medical Provider to Use or Disclose Information (including its agents, employees and associates):

JFK medical Center

I hereby authorize the use and disclosure of my protected health information related to my care, treatment and/or services otherwise known as "Protected Health Information" (PHI), as permitted by the Federal Health Privacy Law (HIPAA), as detailed below:

Information to be used or disclosed:

Dates of Service(s) : 2008 to _____

Specific Description/Type of PHI: All PHI in medical record; all admission form, office notes, reports, opinions, x-rays, MRI, CT or other scans, tests, operative report(s); admission forms, dictation reports, physician orders, intake/outtake/clinical tests/ medication sheets; operative information, Cath, lab reports, special test/therapy, rhythm strips, nursing information, transfer forms, ER information, itemized bill including, but not limited to HCFA or UB-92, and all records to be provided to you by other medical providers/facilities.

To Whom Information May Be Disclosed/Released to:
The Law Office of: Babbitt, Johnson, Osborne & Le Clainche, P.A. and any of its employees or representatives, and specifically Chashae Whitehead as (Paralegal) for the firm.

Reason(s) for Use or Disclosure): (At the request of the Patient)
In order for my attorney representing me from the Law Office of Babbitt, Johnson, Osborne & Le Clainche, P.A. to adequately and properly investigate and handle my potential claim.

*Authorization will expire one (1) year from the date of signature unless revoked or terminated by Patient.*
A photocopy of this authorization is to be considered as valid as the original.

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

I acknowledge and hereby consent to the release of alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Patient's initials)

I have read the above and authorize the disclosure of the protected health information as stated.

| | |
|---|---|
| Norma Blake | |
| Signature | Date 7-15-11 |
| NORMA BLAKE | |
| Print Name | Relationship to Patient of Personal/Legal representative signing for Patient: |

ONE PAGE OF CONFIDENTIAL MEDICAL RECORDS INTENTIONALLY REDACTED

ONE PAGE OF CONFIDENTIAL MEDICAL BILLS
INTENTIONALLY REDACTED

ONE PAGE OF CONFIDENTIAL MEDICAL RECORDS INTENTIONALLY REDACTED